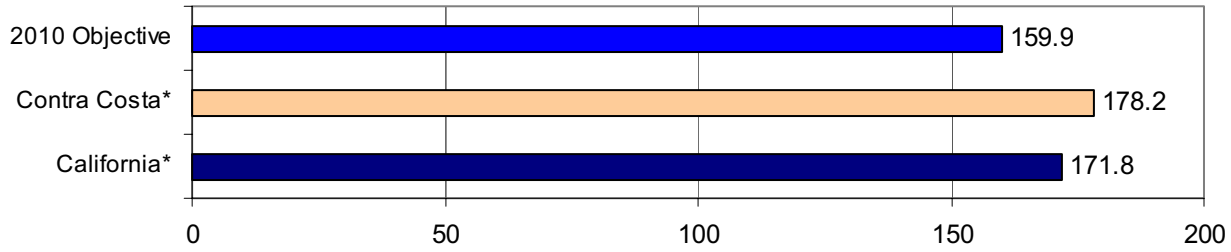
Cancer – All Types

Contra Costa has not met the Healthy People 2010 objective of reducing the age-adjusted death rate from cancer to no more than 159.9 deaths per 100,000 residents.

Figure 5. Age-adjusted death rates from cancer



[*] Indicates that the age-adjusted death rates per 100,000 for Contra Costa and California are significantly higher than the 2010 Objective. Contra Costa and California statistics were calculated for the three-year period 2000-2002.

Cancer is the second leading cause of death

In Contra Costa, cancer accounts for 25% of all deaths. Over a three-year period 2000-2002, there were 5,037 Contra Costa residents who died of cancer. This means that **approximately 1,675 Contra Costa residents die from cancer each year**.

The age-adjusted death rate from cancer is higher in Contra Costa (178.2 per 100,000) than California (171.8 per 100,000).

People living in San Pablo, Oakley, Martinez, Brentwood and Richmond, as well as African Americans and men, are more likely to die from cancer compared to the county overall. These differences are not due to the age of the population and are likely due to physical or social environmental risks, unhealthy behaviors or inadequate access to health services.

Some communities have higher rates of cancer deaths

Residents of San Pablo, Oakley, Martinez, Brentwood and Richmond are more likely to die from cancer compared to the county overall.

Table 30. Cancer deaths in selected communities. Contra Costa, 2000-2002

	Rate	Percent	(Number)
San Pablo	*321.3	4%	(219)
Oakley	*273.0	2%	(105)
Martinez	*254.6	5%	(248)
Brentwood	*216.0	3%	(131)
Richmond	*215.8	11%	(549)
Bay Point	207.4	2%	(78)
Walnut Creek	194.2	15%	(775)
Concord	185.4	12%	(620)
Antioch	185.3	7%	(360)
Pittsburg	185.1	5%	(236)
Pinole	175.8	2%	(111)
Contra Costa:	**178.2**	**100%**	**(5,037)**

[*] Indicates that the age-adjusted death rate per 100,000 is significantly higher for people living in these communities compared to Contra Costa as a whole.

The greatest number of the deaths from cancer occurs among people living in Walnut Creek (775, 15%), followed by people living in Concord (620, 12%), Richmond (549, 11%), Antioch (360, 7%), Martinez (248, 5%) and Pittsburg (236, 5%).

There are unfair racial differences in cancer deaths

African Americans are more likely to die from cancer compared to Contra Costa as a whole. Asians and Latinos are less likely to die from cancer compared to the county as a whole.

Table 31. Cancer deaths by race/ethnicity. Contra Costa, 2000-2002

	Rate	Percent	(Number)
African American	*247.6	10%	(498)
White	187.2	77%	(3,895)
Asian	123.2	7%	(337)
Latino	122.6	6%	(280)
Contra Costa:	**178.2**	**100%**	**[1](5,037)**

[*] Indicates that the age-adjusted death rate per 100,000 is significantly higher among African Americans compared to Contra Costa as a whole.
[1]The Contra Costa total also includes the 27 deaths that occurred among people from other race/ethnic groups such as Native American and Alaska Natives, Native Hawaiians and Pacific Islanders and people from two or more race groups. Due to small numbers (<20 deaths), rates could not be calculated for these groups.

The greatest number of deaths from cancer occur among Whites (3,895, 77%), **followed by African Americans** (498, 10%), Asians (337, 7%) and Latinos (280, 6%).

Men are more likely to die of cancer

Men have significantly higher death rates compared to the county as a whole.

Table 32. Cancer deaths by gender. Contra Costa, 2000-2002

	Rate	Percent	(Number)
Men	*205.4	48%	(2,412)
Women	161.4	52%	(2,625)
Contra Costa:	**178.2**	**100%**	**(5,037)**

[*] Indicates that the age-adjusted death rate is significantly higher among men compared to Contra Costa as a whole.

Though men are more likely to die from cancer, **over half of the deaths** (2,625) **from cancer occur among women** because there are more women in our senior population. Prevention and early treatment are important.

Cancer is a large group of diseases

For most types of cancer, abnormal cells form a lump or mass called a tumor. If cells from the tumor break away and travel to other parts of the body, they can continue to grow and damage the surrounding tissues and organs.

If the spread of abnormal cells is not controlled or checked, it can result in death. However, **many cancers can be cured through early detection and prompt treatment**.

Nationally, **African Americans are about 34% more likely to die from cancer than Whites**, and more than two times more likely to die from cancer than Asian/ Pacific Islanders, American Indians, and Latino. Racial and ethnic minorities tend to receive lower quality health care than Whites do. Access to good medical care is crucial to cancer survival.

Cancer is a chronic disease that is heavily influenced by age. This means that people become much more likely to develop and die from cancer as they get older. We have no control over some of the risk factors for cancer such as age or family history of cancer. We do have control over other important risk factors including cigarette smoking, diet and exercise. Many cancers can be prevented through lifestyle changes.

Using this data to improve community health

In order to reduce unfair health differences, it is important to target the groups with the highest age-adjusted death rates. For cancer, these are people living in San Pablo, Oakley, Martinez, Brentwood, and Richmond, and African Americans and men.

In order to reduce the overall number of deaths in the county (without regard to health disparities) it may be better to target interventions to the group that accounts for the greatest number of deaths from a given cause. For cancer, these are Whites, African Americans, and people living in Walnut Creek, Concord and Richmond.

Access to routine medical screenings and care is important to good health. Many Contra Costa residents diagnosed with chronic diseases like cancer can keep getting sicker when they lack health insurance, transportation or sufficient English skills to navigate health care systems. Providing culturally competent and accessible heath care to all residents will be key to lowering the county's death rates.

Because a person's risk for developing or dying from a chronic disease like cancer increases with age, it is important to target ongoing environmental and behavioral interventions to the young and middle-aged, in addition to older populations. Examples could include strategies to control environmental toxins, limit youth access to cigarettes, increase community access to fruits and vegetables, or educate people about the importance of regular screenings.

Why are age-adjusted rates important?

An age-adjusted rate controls for differences in age distribution and population size. An age-adjusted rate is the best summary statistic for comparing the impact of chronic diseases, like cancer, that are heavily influenced by age.

For example, the White population is older and the Latino population is younger than the county as a whole. Without age-adjustment, we would expect to see higher death rates among Whites than among Latinos, and we would expect that these differences would be largely due to age. An age-adjusted rate calculates what the death rates would look like if the White and Latino populations had the same age distribution. The age-adjusted death rate is useful in **identifying differences that are due to poor access to health care or environmental and behavioral risk factors** instead of age. (See the Methods section at the back of this report for more information about using rates.)

The differences highlighted above are statistically significant. This means that we are 95% certain that these differences are not due to chance.

How to calculate the percent and number of deaths

Percentages describe the proportion of countywide deaths from cancer that occur within a particular community, race/ethnic group or gender. The percentage is calculated by dividing the number of deaths that occur within a specific community, race/ethnic group or gender by the total number of deaths countywide and then multiplying that number by 100.

Numbers show the actual number of deaths from each cause over a three-year period. The number of deaths per year can be calculated by dividing the total number of deaths from 2000-2002, as shown in the tables, by three.

Confidence intervals are available
You may download and view all detailed tables with 95% confidence intervals, at http://cchealth.org/health_data/hospital_council/

Data sources

Mortality data from the California Department of Health Services (CDHS), http://www.dhs.ca.gov/, Center for Health Statistics' Death Statistical Master File, 2000-2002. Any analyses, interpretations or conclusions of the data have been reached by CHAPE and are not from the CDHS.

Population data from the California Department of Finance, Race/ Ethnic Population with Age and Sex Detail, 2000-2050, and E-4 Population Estimates for Cities, Counties, and the State, 2001-2004, with DRU Benchmark, available online at: http://www.dof.ca.gov/HTML/DEMOGRAP/Druhpar.htm. Sacramento, California, May 2004.
Note: City-level denominators were extrapolated from the E-4 file to approximate the mid-year city-level population estimates that are needed to calculate city-level rates. For more information, please see our section on statistical methods.

ICD10 coding for malignant neoplasms (ICD C00-C97) from the Centers for Disease Control and Prevention National Center for Health Statistics, available online at: http://www.cdc.gov/nchs/data/nvsr/nvsr50/nvsr50_16.pdf.

Healthy People 2010 objectives from the US Department of Health and Human Services' Office of Disease Prevention and Health Promotion, available online at http://www.healthypeople.gov/.

Information about how cancer affects the body, and risk factors for cancer from the Alameda County Public Health Department's Community Assessment, Planning, and Education (CAPE) unit's Alameda County Health Status Report 2003, available online at http://www.co.alameda.ca.us/PublicHealth/index.htm.

Information about national health disparities from Landis, SH; Murray, T; Bolden, S; et al. Cancer statistics, 2000. CA: A Cancer Journal for Clinicians 50 (1):2398-2424, 2000.